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An Office of the
Department of Health and Human Services

FOR DISCUSSION
DRAFT
PURPOSES ONLY

MaineCare

Value Based Purchasing
Stakeholder Advisory Committee

October 7, 2011

Objectives & Agenda

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Objectives

- Provide overview of the Department's Value Based Purchasing Strategy and a forum for stakeholder questions and feedback.

Agenda

- Welcome and Introductions
- Transition to Value Based Purchasing Strategy
- Overview of Value Based Purchasing Strategy
- Description and Discussion of Strategy Components
  1. Emergency Department Collaborative Care Management Initiative
  2. Accountable Communities Program
  3. Leveraging of current initiatives and federal opportunities
     - Patient Centered Medical Homes + Community Care Teams = Health Homes
     - Primary Care Provider (PCP) Incentive Payment Reform
     - Transparency and Reporting
- Stakeholder Engagement Plan

Overview of Value Based Purchasing Strategy

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Value-based purchasing means holding providers accountable for both the quality and cost of care, through:

- Increased transparency of cost and quality outcomes
- Reward for performance
- Payment reform

The Department has developed a three-pronged value-based purchasing strategy to achieve target savings and improved health outcomes.

1. Emergency Department Collaborative Care Management Initiative
2. Accountable Communities Initiative
3. Leveraging of current initiatives and federal opportunities
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   - Transparency and Reporting

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1. Emergency Department Collaborative Care Management Initiative
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1. Emergency Department Collaborative Care Management Project

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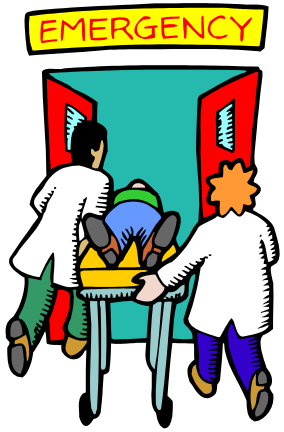
Emergency Department Collaborative Care Management Project Summary and Progress:

- "Boots on the ground" approach to provide team-based care management to MaineCare's highest ED utilizers, identified in conjunction with hospitals.
- Based on successful pilot with MaineGeneral initiated in September, 2010, which achieved a 33% reduction in ED visits by MaineGeneral's 35 highest ED users.
- The Department initiated contact with Maine's 36 hospitals in June and met with all hospitals over the summer.



1. Emergency Department Collaborative Care Management Project: Partnership

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Expectations for participating hospitals:

- Investment of available care management resources for monthly case conferences
- Daily sharing of ED and inpatient census data
- A signed Business Associate Agreement to ensure confidentiality requirements are met

What MaineCare brings to the table:

- Convenes hospital, MaineCare and community resources involved in members' care
- Provides care management resources for hospitals with insufficient capacity
- Analysis of daily census to identify high utilizers, readmissions and patterns of care
- Sharing high utilization costs, diagnosis, medical compliance, PCP provider and visit, and other utilization data*
- Technical assistance

*Excludes HIV and substance abuse data, sharing of which is prohibited by state law

1. Emergency Department Collaborative Care Management Project: Progress & Plans

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Progress to date:

- 23 hospitals have begun providing daily census reports
- 20 hospitals have returned signed Business Associate Agreements
- 19 hospitals have returned the list of members with whom need care management
- 9 hospitals have begun case conferences
- 10 hospitals have case conferences scheduled in the near future

Immediate Plans:

- October 20th MaineCare and Quality Counts is hosting an event with Dr. Jeffrey Brenner on Coordinating Care for High Need Populations.

Vision for the future:

- Foundation building for Accountable Communities program
- Collaboration will continue in areas of the state that may not be served under the Accountable Communities program

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2. Accountable Communities

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The Accountable Communities Initiative can be summarized as:

- Alternative, risk-based contracts with qualified provider organizations that will align financial incentives for providers to work together to improve value and decrease avoidable costs.
- Tiered levels of risk-sharing agreements to enable participation by providers at varying levels of capacity.
- Based on an Accountable Care Organization (ACO) Model.

2. Accountable Communities: What is an ACO?

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The definition of an ACO depends on who you ask…

The Department is adopting the simple definition that an ACO is:

An entity responsible for population's health and health costs that is:

- Provider-owned and driven
- A structure with strong consumer component and local governance
- Includes shared accountability for both cost and quality

2. Accountable Communities: How is an ACO different from a MCO?

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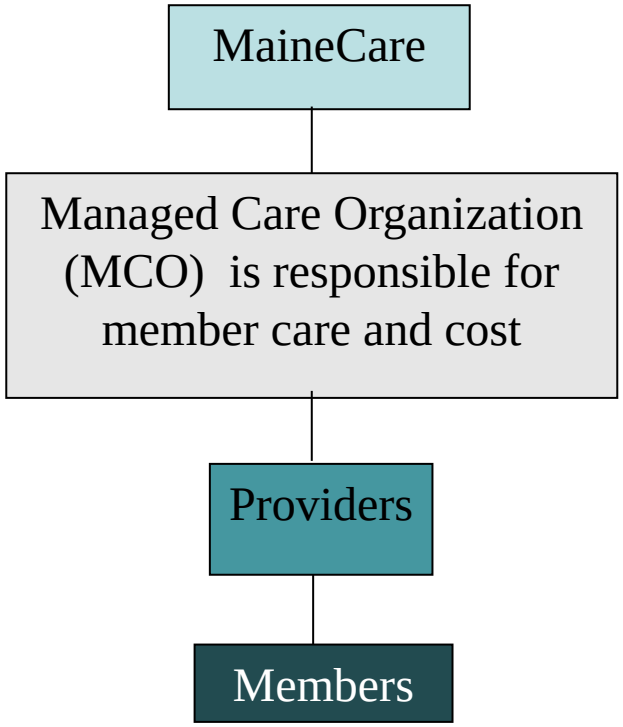
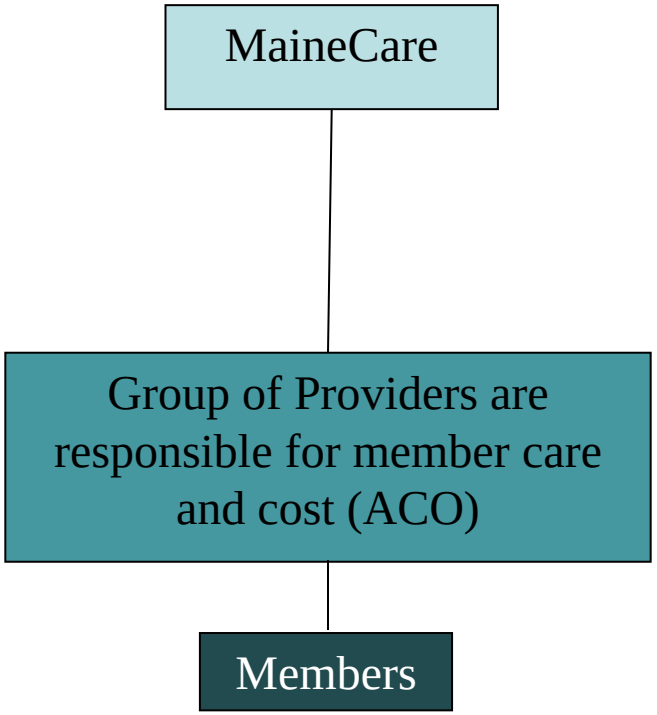
Managed Care Organization (MCO)



Accountable Care Organization (ACO)



2. Accountable Communities: How is an ACO different from Managed Care?

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Managed Care Organization (MCO)	Accountable Care Organization (ACO)
Have traditionally controlled costs through utilization and rate control	Major levers to control costs are care coordination across providers and collaborative approach with member
Members enroll in MCO Health Plan	Members are "attributed" to an ACO but the member may not know s/he is "part" of an ACO
Member choice of providers is limited to providers in MCO network	Members retain choice of providers with an emphasis on development of a relationship between ACO providers and the member

2. Accountable Communities: MaineCare's Basic Model Components

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- Multiple "tiers" of risk (and reward) sharing
- Collaborative approach to design risk-sharing tiers and other aspects of model
- Open to any willing and qualified providers statewide
  - Qualified providers will be determined through an RFP process
  - ACOs will not be limited by geographical area
- Members will retain choice of providers
- Alignment with aspects of other emerging ACOs (commercial, Medicare Pioneer) in the state wherever feasible and appropriate
- Maximize flexibility of design to encourage competitive innovation
- Focus on integration of physical and behavioral health
- Strong interest in proposals to serve highest need populations

2. Accountable Communities: Q & A

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Other questions you likely have:

What providers make up an ACO?

Primary Care Practices, FQHCs, Health Systems, Hospitals, Home Health Agencies, Nursing Facilities, Specialty Groups, mental health agencies and others.

What are the Department's thoughts?

We will likely mandate the inclusion of PCP but remain flexible otherwise and encourage participation of providers serving the highest need populations.

How is an ACO paid? How do payers "align financial incentives" for the ACO to improve health and decrease costs?

- Fee For Service (FFS), capitated rate, bundled payments, incentive payments, shared savings/risk or some combination of the above.
- We expect the payment structure to incent providers to work together to achieve better value care and reduce avoidable costs.

- TBD based on stakeholder input. MaineCare may start with tiered levels of shared savings and risks, and transition all levels toward a partial or full capitation over time.
- ACOs must meet quality benchmarks in order to share in highest possible shared savings.

2. Accountable Communities: Q & A

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For which members is an ACO accountable? What costs?

This varies based on the model. Under a Medicaid ACO, holding an ACO accountable for total costs has additional implications.

What are the Department's thoughts?

TBD with stakeholder input. MaineCare may define a "core" set of members and/or costs to which ACOs will be encouraged to add on to. MaineCare is interested in proposals to serve the highest need populations.

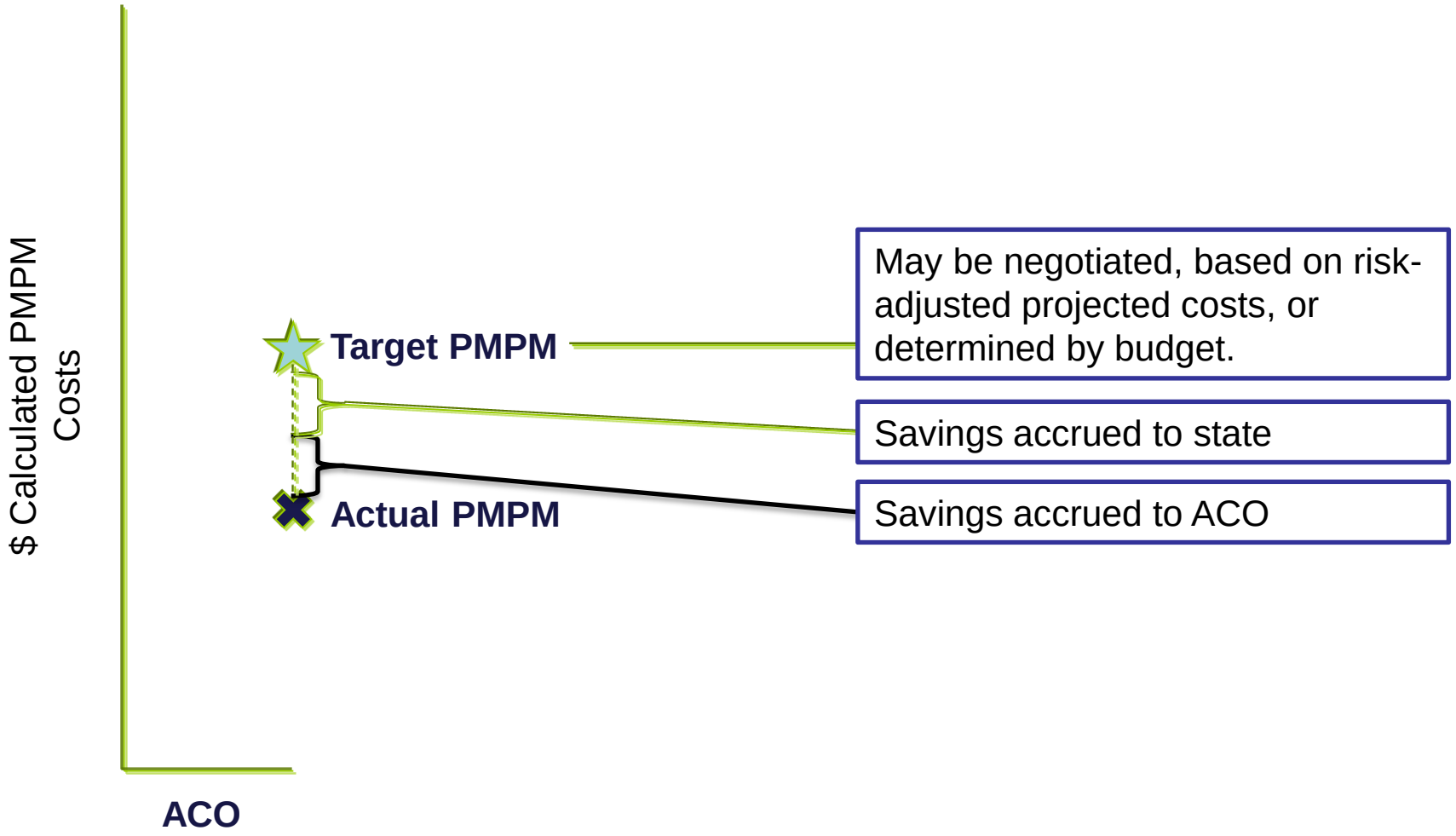
How does an ACO know for which members it is accountable for?

Members may be "attributed" in a few different ways:

- Through an assigned PCP, if applicable (Primary Care Case Management- PCCM)
- Retrospectively: the payer determines which members saw ACO providers for a plurality of their visits at the end of the year
- Prospectively: the payer determines which members will be attributed to the ACO in the beginning of the year, based on where the members have gone in the past.

TBD. The Department may attribute members based on their assigned PCCM PCPs. Members who are not in PCCM would be assigned prospectively based on the PCP that received a plurality of their visits in the past..

2. Accountable Communities: Shared Savings/ Shared Risk Approach



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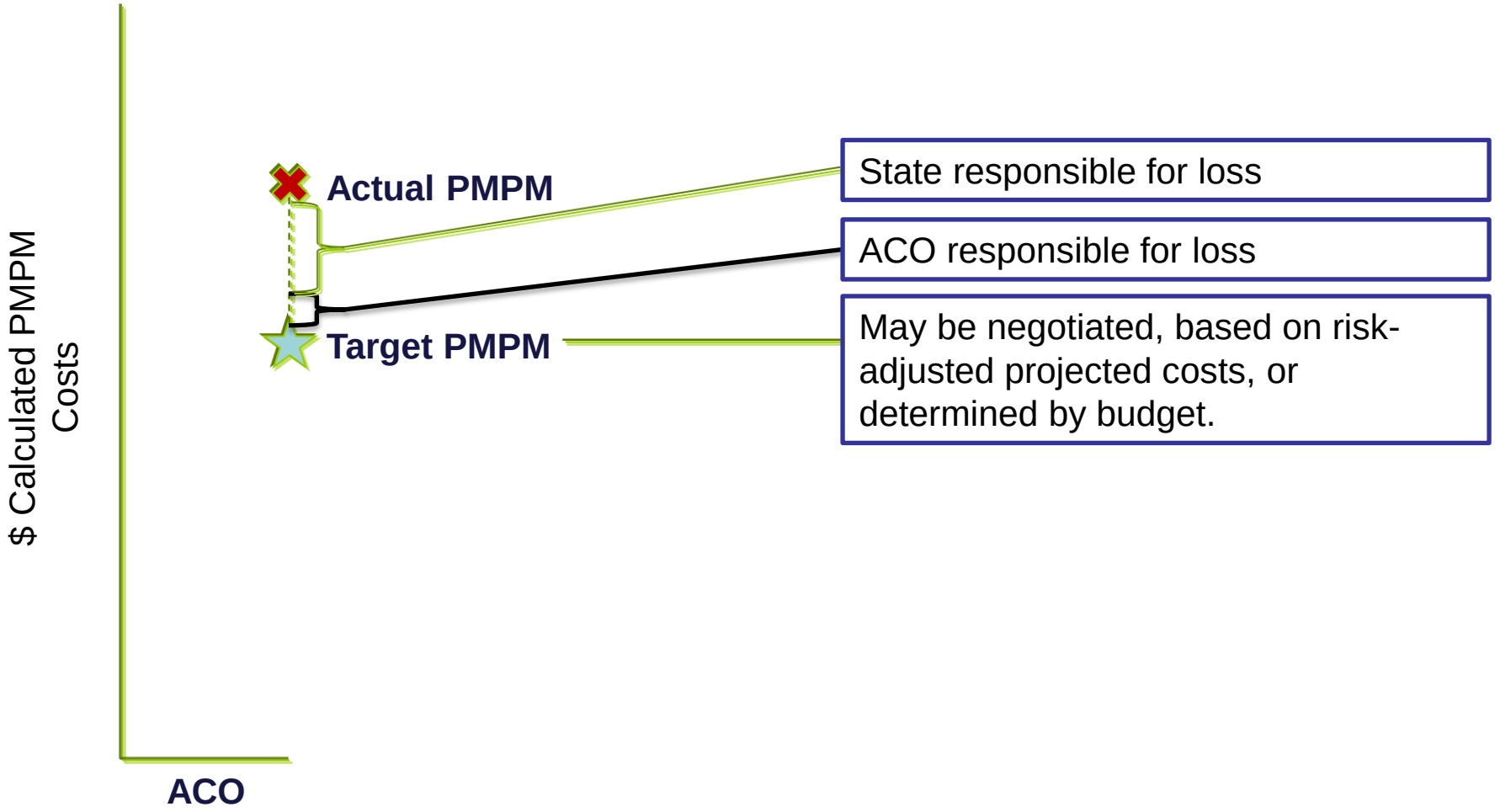

2. Accountable Communities: Additional Considerations

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- Quality Benchmarks:
  - Interest in alignment with commercial ACOs and/or Medicare Pioneer ACO model
  - Consideration of benchmarks developed through Managed Care Initiative
- Consumer Protections:
  - Maintenance of provider choice
  - Focus on care coordination and relationship with member to reduce applicability of comprehensive grievance and appeals process under ACO
  - Prior Authorization activities likely to stay with MaineCare
  - Question of member rights (for example, an ACO denies a request for an MRI because considered inappropriate imaging)
- Federal Authority:
  - CMS acknowledges that FFS vs Managed Care dichotomy does not accommodate intermediate payment reform models well
  - CMS is working to simplify 1915(b) waiver process
  - CMS Innovation Center is working with states on “creative” State Plan Amendments to PCCM and FFS payment methodologies to accommodate shared savings approaches.

2. Accountable Communities: Timeline

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October 2011:
Issue Request for Information (RFI)

November 2011:
Public Forum

January 2012:
Issue RFP

July 1, 2012:
Implementation

---BREAK---

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3. Leveraging Current Initiatives: PCMH + CCT = Health Homes

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Patient-Centered Medical Homes (PCMHs)

Maine has 26 practices engaged in a multi-payer PCMH Pilot.

PCMHs are primary care practices that:

- Care for members using a team approach to care coordination.
- Focus on a long term relationship between member and PCP.
- Have electronic medical records.
- Have open access scheduling and convenient hours.

Community Care Teams (CCTs)

- Are part of Medicare Multi-Payer Advance Primary Care Practice (MAPCP) grant and will be starting in January 2012.
- 8 Community Care Teams will work with 26 PCMHs to coordinate and connect the highest need patients to additional healthcare and community resources.

Health Homes

- PCMHs and the CCTs together enable MaineCare to better serve our highest need populations and qualify for the Affordable Care Act's "Health Home" State Plan option.
- CMS will provide a 90/10 match for Health Home services to members for eight quarters.

3. Leveraging Current Initiatives: Health Homes

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Health Homes serve individuals with:

- Serious and persistent mental illness
- Two or more chronic conditions
- One chronic condition and that are at risk for another

- Chronic conditions include:
  - Asthma
  - Diabetes
  - Heart disease
  - Obesity (BMI >= 25)
  - Mental health condition
  - Substance abuse disorder

- States may conduct a targeted expansion of the Health Homes, either by geography or chronic condition. States may also receive the 90/10 match for eight quarters for members newly served under the expansion.

3. Leveraging Current Initiatives: Health Homes Timeline

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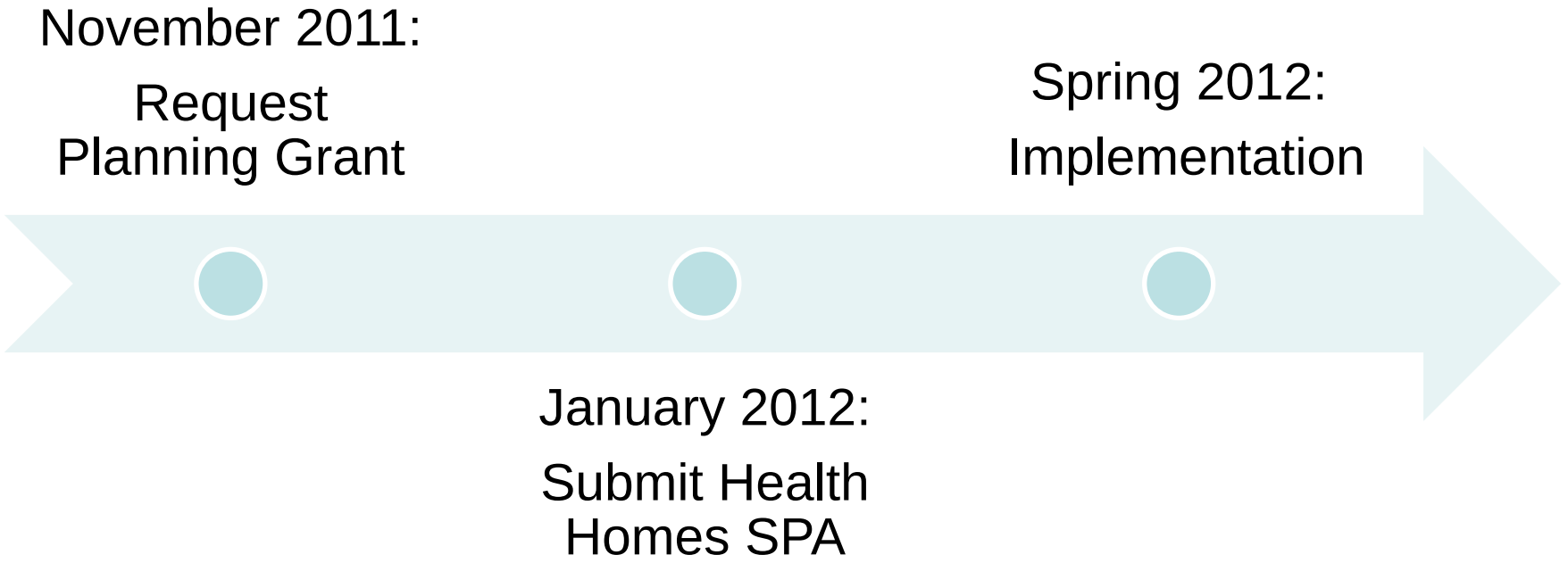
The Department is currently exploring how the enhanced 90/10 match can enable the state to transform additional practices, beyond the 26 PCMHs, to Health Homes.



3. Leveraging Current Initiatives: Primary Care Provider Incentive Program

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The Primary Care Provider Incentive Payment (PCPIP) program provides incentive payments to providers in order to:

- Increase provider access to MaineCare members
- Reduce unnecessary/inappropriate ED utilization
- Increase utilization of preventive/quality services

Providers are ranked according to three areas:

- 40% Access
- 30% Emergency Room use
- 30% Quality of care
  - 20% MaineCare measures
  - 10% Maine Health Management Coalition Pathways to Excellence measures

Providers ranking in the 20th percentile or above receive incentive payments.

From April 1, 2009 to March 31, 2010, 552 providers across 176 sites received a total of $2.6 million (~$4700 per practice) in payments.

3. Leveraging Current Initiatives: PCPIP Reform Ideas

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The PCPIP was last modified in 2007.

While providers have made significant gains opening their doors to MaineCare members, the following concerns remain:

- Providers do not move much within the ranking order
- Maine's ED use is higher than the rest of the country
- MaineCare members are more likely to use the ED than non-MaineCare members
- There is significant variation in ED use across Hospital Service Areas

The Department is exploring ideas to improve the PCPIP program.

These include:

- Requiring either substantial or ranking at least above the mean (or higher)
  - Reducing the number of providers receiving payment to make them higher and more meaningful to those who qualify
- Shift emphasis from access (currently 40%) to other areas
- Stronger alignment of quality measures with Pathways to Excellence to capitalize on multi-payer effort

3. Leveraging Current Initiatives: PCPIP Reform Timeline

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Fall 2011:

Research and discussion

January 2012:

Submit State Plan Amendment

July 1, 2012:

Implementation

3. Improving Current Projects: Transparency & Reporting

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MaineCare wants to improve the transparency of provider performance to the public and MaineCare members.

MaineCare plans to:

- Build off efforts by the Maine Health Management Coalition (Get Better Maine http://getbettermaine.org/) and the State Employee Health Commission)
- Highlight preferred providers for informational purposes
- Make information easily accessible on the Department and MaineCare websites

Fall 2011:

Planning & Collaboration

Spring 2012:

Implementation

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Stakeholder Engagement Plan

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Fall 2011:
1:1 meetings with providers and other stakeholders as appropriate

October 2011:
Issue Request for Information (RFI) on Accountable Communities and other initiatives

November 2011:
Public Forum on Accountable Communities

December 2011:
Reconvene Stakeholder groups if necessary

January 2012:
Issue Accountable Communities RFP